DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 4

2. STATE: Nevada

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 438

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ None
b. FFY 2005 $ None

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Section 3.5, pages 31e through 31t~~
Attachment 3.1-F, pages 1-21

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Section 3.5, pages 31e through 31j

10. SUBJECT OF AMENDMENT:
Medicaid Managed Care Organizations

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, DHR

15. DATE SUBMITTED:

16. RETURN TO:
John A. Liveratti, Chief
DHCFP/Nevada Medicaid
1100 East William Street, Suite 102
Carson City, Nevada 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 23, 2003

18. DATE APPROVED: September 4, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Citation	Condition or Requirement

1932 (a)(1)(A)

A. Section 1932 (a)(1)(A) of the Social Security Act.

The State of Nevada enrolls Medicaid recipients on a mandatory basis into managed care entities (i.e. managed care organization (MCOs) and primary care case managers (PCCMs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid recipients to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plan (PIHP) or to mandate the enrollment of Medicaid recipients who are Medicaid eligible, who are Indians (unless they would be enrolled in certain plans—see IV.2 below), or who meet eligible certain categories of "special needs" beneficiaries (see IV.3-7.)

B. General Description of the Program and Public Process.

1932 (a)(1)(B)(i) or PCCM.
1932 (a)(1)(B)(ii)
42 CFR 438.50 (b)(1)

1. Describe the contracting entities by indicating if they are an MCO

An HMO must be in compliance with all applicable Nevada Revised Statutes, Nevada Administrative Code, the Code of Federal Regulations, the United States Code, and the Social Security Act which assure program and operational compliance as well as assuring services that are provided to Medicaid recipients enrolled in an HMO are done so with the same timeliness, amount, duration, and scope as those provided to fee-for-service Medicaid recipients.

The State of Nevada Division of Health Care Financing and Policy (DHCFP – aka Nevada Medicaid) oversees the administration of all Medicaid managed care organizations (MCOs) in the state. Nevada Medicaid operates a fee-for-service and a managed care reimbursement and service delivery system with which to provide covered medically necessary services to its Medicaid eligible population. Contracted Health Maintenance Organizations (HMOs) are currently the sole such managed care entities providing Medicaid managed care in Nevada; at this time, Nevada Medicaid does not contract with PCCMs, PIHPs, or PAHPs.

Citation	Condition or Requirement

Enrollment in a HMO is mandatory for TANF (Section 1931) and CHAP (poverty level pregnant women, infants, and children) recipients when there is more than one HMO option from which to choose in a geographic service area and optional in areas where only one plan exists. The eligibility and aid code determination functions for the Medicaid applicant and eligible population is the responsibility of the Nevada State Welfare Division (NSWD). The enrollment function will become the responsibility of MMIS effective October 1, 2003.

CFR 438.50 (b)(2)
CFR438.50 (b)(3)

2. Discuss the payment method to be utilized (i.e. fee for service, capitation, case management fee, bonus/incentive and/or supplemental payments).

MCO contracts are comprehensive risk contracts and are paid a risk-based capitated rate for each eligible, enrolled Medicaid recipient on a per-member, per-month (PMPM) basis. These capitated rates are certified to be actuarially sound. There is also a formula for stop loss when costs of care exceed a threshold during a specified time period.

CFR 438.50 (b)(4)

3. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.

Pursuant to 42 CFR 438.50(b)(4), the State shall provide public notice to promote public involvement in the design and initial implementation of the program well as during contract procurement. The public notice shall be a notice of publication published in a newspaper in Southern Nevada and in a newspaper in Northern Nevada. The notice of publication will include a statement of the need for amending the state plan and purpose of the proposed amendment, and the substance of the proposed regulation and issues involved and the manner in which interested persons may present their views thereon.

Citation	Condition or Requirement

1932 (a)(1)(A)

4. Affirm if the state plan program will implement mandatory enrollment into managed care on a statewide basis. If not, identify the county/areas where mandatory enrollment will be implemented.

Mandatory enrollment will be implemented pursuant to NAC 695C.160. At the current time, mandatory enrollment occurs in the areas of Clark County and Washoe County which comply with this State Statute.

C. State Assurances and Compliance with the Statute and Regulations.

The state assures all the applicable requirements that include but are not limited to the following statute and regulations are met:

1932 (a)(1)(A)(i)(I)
1903 (m)
438.50 (c)(1)

1. Section 1903 (m) of the Act, for MCOs and MCO contracts.

1932 (a)(1)(A)(i)(I)
1905 (t)
42 CFR 438.50 (c)(2)
1902 (a)(23(A)

2. Section 1905 (t) of the Act for PCCMs and PCCM contracts.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. Section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.

1932 (a)(1)(A)
CFR 431.51

4. 42 CFR 431.51 regarding freedom of choice for family planning 42 services and supplies as defined in Section 1905 (a)(4)(C).

1932 (a)(1)(A)
42 CFR 438
42 CFR 438.50 (c)(4)
1903 (m)

5. 42 CFR 438 for MCOs and PCCMs.

1932 (a)(1)(A)
42 CFR 438.6 (c)
42 CFR 438.50 (c)(6)

6. 42 CFR 438.6 (c) for payments under any risk contracts.

Citation	Condition or Requirement

1932 (a)(1)(A)
42 CFR 447.362
42 CFR 438.50 (c)(6)

7. 42 CFR 447.362 for payments under any non-risk contracts.

45 CFR 74.40

8. 45 CFR 74.40 for procurement of contracts.

D. Eligible groups

1932 (a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

The State of Nevada Managed Care Program requires the mandatory enrollment of recipients found eligible for Medicaid program coverage under the following Medicaid eligibility categories when there are two or more HMOs in the geographic service area:

a. Temporary Assistance for Needy Families (TANF);
b. Two parent TANF;
c. TANF – Related Medical Only;
d. TANF – Post Medical (pursuant to Section 1925 of the Social Security Act (the Act);
e. TANF – Transitional Medical (under Section 1925 of the Act);
f. TANF Related (Sneede vs. Kizer); and,
g. Child Health Assurance Program (CHAP).

2. Mandatory exempt groups

Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.

1932 (2)(B)
42 CFR 438 (d)(1)

i. Recipients who are also eligible for Medicare

___The state will allow these individuals to voluntarily enroll in the managed care program.

Citation	Condition or Requirement

1932 (a)(2)(C)
42 CFR 438 (d)(2)

ii. Indians who are members of Federally recognized tribes, unless the MCO or PCCM is the Indian Health Service; an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service; or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service.

_X_ The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(i)
CFR 438.50 (d)(3)(i)

iii. Children under the age of 19 years, who are eligible for 42 Supplemental Security Income (SSI) under title XVI.

___The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(iii)
42 CFR 438.50 (d)(3)(ii)

iv. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

___The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(v)
42 CFR 438.50 (3)(iii)

v. Children under the age of 19 years who are in foster care or other out-of-home placement.

___ The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(iv)
42 CFR 438.50 (3)(iv)

vi. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

____ The state will allow these individuals to voluntarily enroll in the managed care program.

Citation	Condition or Requirement

1932 (a)(2)(A)(ii);
42 CFR 438.50 (3)(v)

vii. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

X The state will allow these individuals to voluntarily enroll in the managed care program.

E. Identification of Mandatory Exempt Populations.

1932 (a)(2)
42 CFR 438.50 (d)

1. How does the state define children who receive services funded under section 501 (a)(1)(D) of title V?

Children receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a) (1) (D) of Title V are defined as those who receive services at the Special Children's Clinic in Washoe or Clark Counties, or the First Step or Happy Programs in the rural areas.

The State will utilize database information to identify Medicaid recipients receiving these services. Additionally, children needing services from the Special Children's Clinic and the First Step and Happy Programs may be identified by a parent or guardian.

1932 (a)(2)
42 CFR 438.50 (d)

2. Is the state's definition of these children in terms of program participation or special health care needs?

The State's definition of these children is based on program participation and/or parental or legal guardian identification.

1932 (a)(2)
42 CFR 438.50 (d)

3. Does the scope of these title V services include services received through a family-centered, community-based, coordinated care system?

Yes.

Citation	Condition or Requirement

1932(a)(2)
42 CFR 438.50 (d)

4. How does the state identify the following groups of children who are exempt from mandatory enrollment:

i. Children under 19 years of age who are eligible for SSI under title XVI;

All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act

All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care.

iii. Children under 19 years of age who are in foster care or other out-of home placement;

All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care.

1932(a)(2)

5. What is the state's process for allowing children to request an exemption based on 42 CFR 438.50 (d) the special needs criteria as defined in the state plan if they are not initially identified as exempt from mandatory enrollment?

Nevada has a database and self-identification mechanism for children with special health care needs. If a child is identified as a child with special health care needs (CSHCN) following enrollment in an

Citation	Condition or Requirement

HMO, the parent or legal guardian is notified of their right to keep the child enrolled with the HMO or to request the child's disenrollment. If the parent or legal guardian decides to keep the child enrolled, the HMO is required to provide all services available under the Managed Care Contract. In addition, if the Individualized Family Service Plan (IFSP) or Individual Education Plan (IEP) has identified services which are not covered under Medicaid through the EPSDT benefit, or covered under the Managed Care Contract, the HMO is responsible for providing case management services on behalf of the child and family in order to ensure referral and linkage to other community resources in obtaining these identified services. If the parent or legal guardian elects to disenroll the child from the HMO, the child will be disenrolled from the HMO pursuant to 42 CFR 438.56 (e) (1) after which covered medically necessary services will be reimbursed through Medicaid fee-for-service.

1932 (a)(2)
42 CFR 438.50 (d)

6. How does the state identify the following groups who are exempt from mandatory enrollment into managed care:

i. Individuals who are also eligible for Medicare.

Dual Medicare-Medicaid eligibles are identified by aid code. System edits prevent enrollment of these Medicaid eligibles into Managed Care.

ii. Indians who are members of Federally recognized tribes, except when the MCO or PCCM is the Indian Health Service; or an Indian Health program or Urban Indian program is operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

American Indian identifying information, if provided by the recipient, is available from the eligibility system. Identification of American Indians can also occur directly from the recipient, parent, or guardian.

Citation	Condition or Requirement

42 CFR 438.50

F. List other populations (not previously mentioned) who are exempt from mandatory enrollment.

Recipients with comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased from another organization or agency which cannot be billed by a HMO are exempt from mandatory enrollment.

42 CFR 438.50

G. List all other eligible groups that are permitted to enroll on a voluntary basis.

The State assures that although the following Medicaid recipients are exempt from mandatory enrollment, they are allowed to voluntarily enroll in a HMO, if they so choose:

1. TANF and CHAP adults diagnosed as seriously mentally ill (SMI); and,
2. Children diagnosed as seriously emotionally disturbed (SED).

H. Enrollment process.

1932 (a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.